CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
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WEBSITE: WWW.DPR.DELAWARE.GOV

BIENNIAL REGISTRATION/RENEWAL APPLICATION FOR ADVANCED PRACTICE NURSES CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY

(For Office of Controlled Substances Drugs Use Only):				
License No.	**Renewal Date**	**Amt. Rec'd.**	**Check No.**	**Date Rec'd.**

PLEASE PRINT OR TYPE

SECTION A - **PERSONAL DATA** (*Do not use a post office box address*)

NAME AND PRACTICE ADDRESS (LAST, FIRST, MIDDLE INITIAL)	**NAME AND HOME ADDRESS (LAST, FIRST, MIDDLE INITIAL)**

DATE OF BIRTH	**HOME PHONE**	**WORK PHONE**

DRIVER LICENSE NUMBER	**STATE**	**SOCIAL SECURITY NUMBER**

ADVANCED PARCTICE NURSE LICENSE NO.	**EXPIRATION DATE**

PRESCRIBER I.D. NO.

RXAPN: **AREA OF SPECIALTY:**

FEDERAL DEA NO.

SECTION B - **DISCLOSURES**

1. □ Yes □ No Has the applicant ever been convicted of a crime in connection with controlled substances under State or Federal law?

2. □ Yes □ No Has the applicant ever surrendered or had a Federal controlled substances registration revoked, suspended, restricted, or denied?

3. □ Yes □ No Has the applicant ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

4. □ Yes □ No If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder or proprietor been convicted of a crime in connection with controlled substances under State or Federal law, or ever been suspended, restricted or denied, or ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

*** If the answer to any of the above questions is yes, please attach a letter setting forth the circumstances of such action.**

SECTION C - **SCHEDULES REQUESTED**

Registration is requested in the following schedules: □ **II** □ **III** □ **IV** □ **V**

SECTION D - **PRACTICE DATA**

***NAME OF COLLABORATOR:**	**TELEPHONE NUMBER**
BUSINESS ADDRESS OF PRACTICE:	

A Collaborative Agreement with the applicant has been established. I am aware that this application is for a CSA Number in the State of Delaware, and if approved, the applicant will be able to prescribe drugs in the Schedules checked in Section C of this form provided that he/she obtains a DEA number.

AUTHORIZED SIGNATURE_____ **DATE**_____

NAME (*typed or printed*)_____

****** *If more than one collaborative agreement has been established, please provide same information on additional sheets.*

SECTION E - **CERTIFICATION**

I certify that the facts stated in this application are true, complete and correct and that this application is made to obtain biennial registration, pursuant to the Uniform Controlled Substances Act. I will notify the Office of Controlled Substances in writing within 10 days of all changes pertaining to personal data in Section A and practice data in Section D.

MAIL APPLICATION TO: **FEE: $40.00** **(MAKE CHECK PAYABLE TO "STATE OF DELAWARE")**

OFFICE OF CONTROLLED SUBSTANCES
CANNON BUILDING
861 SILVER LAKE BLVD. SUITE 203
DOVER, DELAWARE 19904

_____ _____
(Signature) *(Date)*

_____
NAME (*typed or printed*)

FOR STATE USE ONLY:

VERIFICATION WITH THE DELAWARE BOARD OF NURSING:

NAME_____

OCS PERSONNEL NAME_____ **DATE**_____